# Montana Medicaid Claim Jumper

## Electronic Claims Submission Update

Montana Medicaid providers who submit their electronic claims directly to ACS using field software are successfully transitioning from the outgoing ACE$ software to WINASAP2003, the new HIPAA-compliant software. ACS began accepting and processing HIPAA-mandated ANSI ASC X12N transactions generated and transmitted by WINASAP2003 on October 16, 2003.

Providers and billers who are still using ACE$ to submit their claims electronically, as well as providers and billers who are currently submitting paper claims, are advised to enroll with ACS-EDI Gateway, Inc. and begin submitting claims via WINASAP2003 as soon as possible. Under HIPAA, ACS will not be able to accept and process non-HIPAA-compliant ACE$ electronic transactions after December 31, 2003.

The WINASAP2003 software is free and can be downloaded at *http://www.acs-gcro.com/WINASAP2003/Software_Download/software_download.htm.* Enrollment forms and instructions are available for download at the ACS EDI Gateway Inc. website at *www.acs-gcro.com/Medicaid_Accounts/Montana/montana.htm.* For further information, please call the ACS-EDI Gateway, Inc. Support Unit at (800) 987-6719.

Moreover, ACS will no longer be able to accept and process *any* non-HIPAA-compliant NSF electronic claim transactions after March 31, 2004. All electronic claims must be submitted in the HIPAA-compliant ANSI ASC X12N format by this date, or preferably well in advance of the cut-off date.

Providers who submit electronic claims directly to ACS or those who use a clearinghouse to submit claims should contact ACS-EDI Gateway, Inc. at (800) 987-6719 or their individual clearinghouse for more information about transitioning to the ANSI ASC X12N format.

## NSF Enrollment Procedures

Providers who wish to enroll as an electronic submitter using the NSF format must forward their enrollment application to ACS Provider Relations in Helena along with a letter indicating that they want to be linked to their clearinghouse as an NSF submitter. ACS Provider Relations' mailing address is P.O. Box 4936, Helena, MT 59604.

## WINASAP2003 Notes

Providers setting up WINASAP2003 should ensure that the Montana seven-digit provider ID number is entered in the appropriate field. The submitter/trading partner ID number assigned by ACS-EDI is entered in the Trading Partner set-up screen only. The seven-digit Montana provider ID number is entered in the provider reference database.

In general, the fields that are required to process your claim are underlined in the WINASAP2003 software. However, there may be other fields that are required to process your claim, for example, prior authorization numbers, diagnosis codes, and PASSPORT numbers. WINASAP2003 will allow users to save and transmit claims without entering these fields. Providers must ensure that all the information required to process a particular claim is entered in the appropriate field.

Providers should direct questions regarding WINASAP2003 to the EDI Gateway Support Center at 800-987-6719, Monday through Friday, 8 a.m. to 5 p.m.

Providers with special concerns or training needs regarding electronic claim submission should contact an ACS provider relations field representative at (800) 624-3958 or (406) 442-1837 in Helena or out-of-state.

## Partial Hospitalization Payment

The Department has noticed some problems with payment for partial hospitalization services. Some providers began using the new procedure codes effective September 1, 2003 even though the authorizations contained the old Z codes with revenue code 912. ACS has developed a process to allow payment for these services even though the procedure code on the authorization does not match the code on the claim. ACS will also adjust the claims for partial hospitalization that were previously denied because the procedure codes on the authorization did not match the codes on the claim.

## Vaccines For Children

Effective December 1, 2003 Montana Medicaid will reimburse Vaccines For Children (VFC) administrations using 90471 with modifier "SL," which replaces local code Z0805. Z0805 will no longer be available after December 31, 2003 due to HIPAA. The reimbursement will remain $9.50 per VFC vaccine administration.

The VFC codes as of dates of service October 1, 2003 and after are: 90633, 90645, 90647, 90648, 90657, 90669, 90700, 90707, 90713, 90716, 90718, 90723, 90732, 90744, and 90748.

## Bilateral X-ray Reimbursement

The Department has received several requests to review the reimbursement policy for bilateral x-rays. At present, the policy is to pay 150 percent of the fee schedule rate for the x-rays. Billers have been instructed: *When billing modifier 50 for bilateral services, put all information on one line with one unit. You will not need to use modifiers for left and right, and do not bill on separate lines.*

The Department has reviewed this policy and effective January 1, 2004, providers can bill bilateral x-rays using modifiers RT and LT, thus reimbursing each x-ray at 100 percent of the fee schedule. This updated policy will also more easily facilitate the Medicare cross-over claims adjudication process.

## Contraceptive Supplies

In accordance with HIPAA, Medicaid cannot utilize local codes (codes that are not nationally used, i.e. found in the CPT or HCPCS books). The Physician Program has been using local code Z0695 in order to provide reimbursement for contraceptive supplies. This code will no longer be available effective December 31, 2003.

Z0695 will be replaced by:

A4266 = diaphragm
A4267 = male condoms
A4268 = female condoms
A4269 = spermicide
S4993 = oral contraceptives

These codes will continue to price at $45.00 per unit.

## Botox Injections Criteria

The Department has been asked to reconsider the prior authorization criteria for Botox injections that went into effect July 1, 2003. The Department has reviewed the criteria and has decided to expand the criteria to more closely match Medicare's Botox criteria. The updated criteria will be backdated to July 1, 2003. Therefore, prior authorization will be available via post-service request for dates of service July 1, 2003 through December 1, 2003. The prior authorization requests can be faxed to 406-444-0778. Once authorization is obtained, rebill the service using the prior authorization number provided. For a copy of the full Botox criteria, please contact the ACS Provider Relations Unit.

## Hard Card Reminder

Providers should not use the control number printed on the client's *Montana Access to Health* hard card to bill Medicaid. Providers must use the nine-digit client identification number to bill Medicaid.

Visit *www.mtmedicaid.org* for the latest information about Montana Medicaid

## EMTALA Policy Change

The Department is changing policy to conform to the new provisions of EMTALA which go into effect November 10, 2003. We will reimburse, as required by the Balanced Budget Act, for EMTALA-required screenings at any additional facilities which are included in the updated EMTALA definition of "dedicated emergency departments" (DED). This pertains only to the screenings for those people who come to the facility seeking emergency care.

Hospital-owned urgent care facilities, regardless of provider-based designation, that are able to show the Department they meet the updated definition of "dedicated emergency department," and bill on a CMS 1500 form will be re-enrolled as a physician with a provider specialty of (42). If you believe your facility qualifies as a dedicated emergency department, contact the ACS Provider Relations Unit to update your provider specialty. The Department will reimburse in the following manner:

*For those presenting at the urgent care facility for non-emergent care,* PASSPORT provider authorization is required per the PASSPORT regulations.

*For those presenting at the urgent care facility seeking emergency services where an emergency was found to exist,* the Department will reimburse for that emergent care. It has always been Department's policy to pay for screens and for necessary emergency treatment without PASSPORT approval in emergency rooms, and also to pay for emergency services without PASSPORT authorization wherever such services are rendered. Because emergencies are rarely treated outside of hospital emergency rooms, the Department requires documentation of the emergency condition when reimbursing for emergencies treated outside of the emergency room. The claim and documentation can be sent to: Mountain Pacific Quality Health Foundation, 3404 Cooney Drive, Helena, MT 59602.

*For those presenting at the urgent care facility seeking emergency services where an emergency was found not to exist,* the Department will pay a screening fee. The screening will be reimbursed at the lowest level office evaluation and management code. In these situations only, please enter **9930006** in box 17a. Place of service will be unchanged with this new billing procedure.

In all the situations described above, only one 1500 claim form can be submitted for each service. If someone comes seeking emergency medical services, but no emergency is deemed to exist, the provider can bill for the screening fee using 9930006. However, if PASSPORT authorization is obtained, the provider cannot bill for both the screening fee and additional services.

## Cost Avoidance: Pharmacy And Dental Providers

On January 1, 2004, the Department of Public Health & Human Services will no longer allow pharmacy and dental providers to submit claims to Medicaid before submitting the claim to an applicable client's Other Health Insurance (OHI). The Cost Avoidance waiver, which allowed the Department to "pay and chase" claims for clients with OHI, expires on that date. Providers will be required to bill the client's OHI carrier prior to submitting the claim to Medicaid. Look for specific program provider notices.

## Usual And Customary Charge (UCC)

For all purposes under the Medicaid Program, the amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers. In regards to Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEOPS), the charge is considered reasonable if less than or equal to the manufacturer's suggested list price.

For items of DMEOPS without a manufacturer's suggested list price, the charge is considered reasonable if the provider's acquisition cost of the provider is no more than 50 percent of the providers charge amount. Items that are custom fabricated at the place of service, the amount charged will be considered reasonable if it does not exceed the average charge of all Medicaid providers by more than 20 percent.

For the latest Medicaid news, visit the Provider Information website at *www.mtmedicaid.org*. All provider manuals, updates, notices, fee schedules, and other useful documents are available for reference and/or download at the site.

## New Program To Decrease Inappropriate Utilization And Enhance Quality Of Life For Clients

Montana's new Nurse First Advice Line, part of the State's asthma, cancer, chronic pain, heart failure and diabetes disease management program, encourages Medicaid clients to decrease inappropriate utilization of healthcare services while ensuring appropriate services are accessed when medically necessary. This is accomplished through recommendations provided by highly qualified registered nurses.

The new program provided by the Montana Department of Public Health and Human Services and administered by the McKesson Corporation, provides disease management and nurse advice services to approximately 75,000 Medicaid clients throughout the state. The program is scheduled to launch in early December.

Medicaid clients who call the nurse advice line are guided through a series of questions, which help the nurse make a care recommendation based on the acute symptoms described by the client. The nurses use patented algorithms, combined with years of clinical nursing experience, to provide recommendations for symptomatic medical conditions. Depending on the symptoms described by a caller, these recommendations can range from treating a minor injury at home to receiving immediate screening for emergency care.

McKesson has over 15 years experience providing nurse advice lines to State Medicaid programs, the Department of Defense and private health care insurers, and serve over 22 million people. McKesson's nurse advice lines have successfully provided recommendations that enable callers to use the most appropriate healthcare services. The advice line is toll-free and available 24-hours-a-day, 7-days-a-week.

Nurse advice lines result in decreased inappropriate utilization by redirecting callers to the appropriate level of care. Based on care intent when calling the nurse advice line, callers historically have received the following suggestions from the nurse advice line:

- "Downward" recommendation: 54.4 percent
- "Same level of care" recommendation: 26.6 percent
- "Upward" recommendation: 19 percent

While the majority of callers to the nurse advice line received a downward recommendation for care, such as seeing a physician rather than going to the emergency department, many callers received a recommendation to seek a higher, more immediate level of care. In either case, the objective of the nurse advice line is to help ensure that Montana Medicaid clients utilize the most appropriate healthcare services as indicated by the acute symptoms that are described to the nurse.

The Nurse First Advice Line was also developed to accomplish the following goals and objectives that benefit Providers:

- Decrease evening/weekend provider on call traffic by providing 24 x 7 access to an RN for client concerns
- Reduce the no show rates of Medicaid clients
- Improve the patient-provider relationship by informing and educating the client and therefore making them a more active participant in their care
- Allow the provider to focus on higher acuity patients

For more information, contact Jackie Thiel, QA Program Officer, or Tedd Weldon, Care Management Program Officer, at (406) 444-4540.

## Attention: Psychologists, Social Workers And Licensed Professional Counselors

Please remember that **outpatient psychotherapy for adult Medicaid recipients is not covered unless the person meets the criteria for Severe Disabling Mental Illness.** Some providers are continuing to submit claims for clients who do not have a covered diagnosis. Payments made on these cases are subject to review and recovery of payment. As is clearly stated in the 2003 Mental Health Manual, do not assume that payment of a claim means the service was billed or paid correctly. All claims are subject to post-payment review and possible recovery of over-payments.

# Recent Publications

The following are brief summaries of publications regarding recent program policy changes. For details and further instructions, download the complete notice from the Provider Information website (http://www.mtmedicaid.org). Select Notices and Replacement Pages, and then select your provider type for a list of current notices. If you cannot access this information, contact provider relations.

## *New* Notices

**12/01/03 Pharmacy & Dental Providers**

Effective 01/01/04, providers required to bill other insurance prior to submitting claims to Medicaid

**11/10/03 Physicians, Mid-levels, Public Health Clinics, Outpatient Hospitals**

New EMTALA Policy

**10/30/03 Hospitals**

Continued Stay Review
Emergency diagnosis code list

**10/17/03 UB-92 Billers**

Q&A: Reporting ICD-9-CM codes

**10/16/03 Pharmacy Providers**

Prior Authorization Change - Prilosec

**10/14/03 UB-92 Billers**

Form locator update

**10/12/03 Schools**

CSCT program changes


## Spring Medicaid Provider Fair

Mark your calendars for April 27 & 28, 2004. That is when the Spring Medicaid Provider Fair will be held at the Great Northern Hotel in Helena. Further details and registration information will be published in an upcoming issue of the *Claim Jumper* and will be posted at *www.mtmedicaid.org.*

**Montana Medicaid**
**ACS**
**P.O. Box 8000**
**Helena, MT 59604**

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## Key Contacts

**Provider Information Website:** http://www.mtmedicaid.org
**ACS EDI Gateway Website:** http://www.acs-gcro.com/Medicaid_Accounts/Montana/montana.htm
**ACS EDI Help Desk** (800) 987-6719
**Provider Relations** (800) 624-3958 Montana
(406) 442-1837 Helena and out-of-state
(406) 442-4402 fax
**TPL** (800) 624-3958 Montana
(406) 443-1365 Helena and out-of-state
**Direct Deposit Arrangements** (406) 444-5283
**Verify Client Eligibility:**
FAXBACK (800) 714-0075
Automated Voice Response (AVR) (800) 714-0060
**Point-of-sale Help Desk for Pharmacy Claims** (800) 365-4944
**PASSPORT** (800) 624-3958
**Prior Authorization:**
DMEOPS (406) 444-0190
Mountain-Pacific Quality Health Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7961

**Provider Relations**
**P.O. Box 4936**
**Helena, MT 59604**

**Claims Processing**
**P.O. Box 8000**
**Helena, MT 59604**

**Third Party Liability (TPL)**
**P.O. Box 5838**
**Helena, MT 59604**